

MEDICAL EDUCATION AND PRIMARY HEALTH CARE

Edited by HORST NOACK

(Excerpts)



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Preface <i>Hannes G. Pauli</i>	11
Foreword <i>Horst Noack</i>	13
Acknowledgements	17
PART I: INTRODUCTION	19
PART II: THE RELATIONSHIP BETWEEN HEALTH AND MEDICAL EDUCATION	
Introductory Remarks	25
The Health Services and Manpower Development Concept – Health Manpower: For What? <i>Tamas Fülöp</i>	27
Morbidity, Illness Behaviour and the Medical Model <i>Horst Noack and Hans R. Mattias Müller</i>	39
Health Care and the Structure of Medical Education <i>David Armstrong</i>	81
Health Needs, Health Teams and the Co-ordination of Health Care and Medical Education <i>Working Groups</i>	93
Concluding Remarks	97
PART III: PRIMARY HEALTH CARE	
Introductory Remarks	101
Primary Health Care as a Concept and as an Organisational Structure <i>Marshall Marinker</i>	103
Comparisons of Patterns of Work in Hospital Specialist and General Practice <i>John Fry</i>	112
Professional Requirements in Primary and Specialised Care: Implications for the Scope and Type of Learning Situations <i>Daniel M. Barr</i>	118
Characteristics of Primary Health Care <i>Working Groups</i>	131
Concluding Remarks	138
PART IV: THE PROCESS AND CONTEXT OF MEDICAL EDUCATION	
Introductory Remarks	141
The Process of Becoming a Physician and the Context of Medical Education <i>Samuel W. Bloom</i>	144

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10. Professional Socialisation and Medical Care <i>Judith T. Shuval</i>	161
11. Deficiencies of Medical Education and Training <i>Working Groups</i>	176
Concluding Remarks	180

PART V: PLANNING EDUCATION AND TRAINING IN PRIMARY CARE

Introductory Remarks	185
12. Problem-based Learning in Medicine <i>Michael A. Simpson</i>	187
13. The Participation of Provider Staff in the Development of a Curriculum for Primary Care Physicians <i>Edwin B. Hutchins</i>	193
14. The Assessment of Physician Performance in Primary Health Care <i>John C. Sibley</i>	202
15. Towards Educational and Training Programmes in Primary Health Care <i>Working Groups</i>	214
Concluding Remarks	224

PART VI: LEARNING ENVIRONMENTS FOR EDUCATION AND TRAINING IN PRIMARY HEALTH CARE

Introductory Remarks	229
16. Interpersonal Relations in Health Care Delivery and the Development of Interpersonal Skills <i>Rebecca Bergman</i>	231
17. To What Extent can Primary Care Physicians be Trained in Specialised Care Settings? <i>Theodor Abelin</i>	238
18. Teaching Primary Care Medicine in Comprehensive Clinical Care Units <i>Hugo Studer</i>	250
19. Integrating Family Medicine into the Undergraduate Curriculum <i>Carl A. Moore</i>	257
20. Learning Environments and Learning Experiences in Primary Health Care <i>Working Groups</i>	263
Concluding Remarks	272

PART VII: THE ROLE OF THE CLINICAL DISCIPLINES AND OF THE BASIC AND SOCIAL SCIENCES

Introductory Remarks	277
21. The Role of the Clinical Disciplines in the Education and Training of the Primary Care Physician <i>Lawrence R. Freedman</i>	280

22. The Role of the Basic Sciences in the Education and Training of Primary Care Physicians <i>Robert W.S. Tomlinson</i>	287
23. Integrating Medical Sociology into the Medical Curriculum <i>Johannes Siegrist</i>	294
24. The Role of the Behavioural and Social Sciences in Medical Education <i>Margot Jefferys</i>	300
25. The Importance of Epidemiology and the Social Sciences <i>Working Groups</i>	306
Concluding Remarks	308
 PART VIII: CONCLUSIONS AND IMPLICATIONS	311
Epilogue: Medical Education and Primary Health Care: a Critical Review <i>Michael A. Simpson</i>	321
Programme of the Conference	328
Chairpersons and Rapporteurs of Working Groups	334
Additional Conference Papers	336
Notes on Contributors	338
Suggested Reading	342
General Index	345

PART VIII: CONCLUSIONS AND IMPLICATIONS

In any functioning health services system there must be a balance between self-care, primary care and specialised care. A strong system of primary health services is likely to be a key for achieving and maintaining such a balance.

Primary Health Care

Primary Health Care addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly. Since these services reflect and evolve from the economic conditions and social values of the country and its communities, they will vary by country and community, but will include at least: promotion of proper nutrition and an adequate supply of safe water; basic sanitation; maternal and child care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; education concerning prevailing health problems and the methods of preventing and controlling them and appropriate treatment for common diseases and injuries. (WHO, 1978, p.2)

This statement, prepared for the International Conference on Primary Health Care held in Alma-Ata, USSR, in September 1978, summarises the content and the range of primary health services described in different parts of this book.

Considering medical education and training, there is a temptation to define this concept in the more restricted sense of primary medical care, as in several parts of this book. However, this raises several questions. For example, what are the boundaries between the medical and the non-medical components of promotive, preventive, curative and rehabilitative services? Are there meaningful boundaries between the professional roles and requirements of primary care physicians and primary care nurses? It has been noted that usually such boundaries are blurred; and perhaps they must be blurred if primary and other health services are to function properly. Thus, in health and educational planning a relatively broad concept of primary health care has several advantages; frequently such a concept will be necessary.

The main function of primary health services is to meet the basic

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health needs of the populations they serve. Primary health care must therefore be easily accessible, continuously available, comprehensive in scope; and it must co-ordinate all the health care provided to individuals, families and other groups. In the conference as well as in the literature (e.g. Parker, 1974, 1976; CERI, 1975), these were considered *essential* characteristics of primary care, regardless of its organisational structure. Specialised hospital and ambulatory services, on the other hand, have more specific functions, and differ from primary services not only in such visible characteristics like organisation of work or health problems encountered, but also in more subtle aspects such as clinical reasoning or the deliberate use of the factor of time in problem-solving.

It has been observed that frequently primary health services do not meet the essential criteria of primary care. For example, they may be highly fragmented, offer episodic rather than continuous care, use mainly curative strategies and show little concern about health education and prevention. Among other factors, such deficiencies may depend upon the organisational structure of primary care, the education and training of physicians or, as these factors usually interact, on both. As noted in this book and elsewhere there are marked differences among countries in how primary care is organised (solo practice, group practice, community health centre), who provides it (general practitioners or family physicians, specialists, multi-professional teams), and how primary care physicians are educated and trained (see, for example, Council of Europe, 1973; Parkhouse, 1974).

It has been postulated in this book and elsewhere that the work environment may be the more decisive factor in determining the nature and quality of primary care. A study by Rhee (1977) seems to support this view. In this study the physicians' work environments were found to have more influence on the quality of care than their formal training, but the environmental influence was stronger for the less well-trained than for the well-trained physicians. Nevertheless, undergraduate education, postgraduate training and continuing education are likely to have some influence on the nature and quality of primary care, especially if they are directed towards primary health care.

Planning effective educational or training programmes in primary care first of all requires a sufficiently clear concept of the functions and the organisational structure of primary health care in the future, as well as of the professional roles and requirements of primary care physicians. Furthermore, it requires some knowledge about the relationship

between the systems of medical education and training and of primary health care; about how each system influences the other. In this book two questions have been of particular concern: What is the potential contribution of primary health care to medical education and training? What is the potential contribution of medical education and training to primary health care?

The Contribution of Primary Health Care to Medical Education and Training

In many countries there is a distinct separation between the systems of primary health care and of medical education and training. Frequently, medical faculties and staff of other training institutions are unfamiliar with the field of primary health care.

Thus, communication of information about important characteristics of primary care might be crucial; for example, about the nature and extent of health problems or needs encountered; the organisation and management of primary care institutions; the peculiarities of problem-solving and social relations, in particular of the doctor-patient relationship; about difficulties in providing primary health care and inadequate resources; and about educational needs of primary care providers. Although improving the communication between hospital physicians and primary care providers may be of considerable value, as suggested by several contributions to this book, it will not be sufficient. A far more systematic approach seems to be needed, e.g. an appropriate information system.

Primary care institutions can, of course, contribute more directly to medical education and training by providing suitable learning environments and learning situations. This would normally mean that primary care doctors (and other qualified health professionals such as nurses or social workers as well) act as role-models, clinical teachers, tutors or supervisors in their own work settings. Furthermore, they may participate in classroom or clinical teaching, as well as in educational planning and evaluation, at the national, institutional or departmental level.

The Contribution of Medical Education and Training to Primary Health Care

Medical schools and other research or training institutions seem to influence the primary care system (and other segments of the health care system as well) in at least two different ways. At a global level they create and communicate professional orientations as well as basic

assumptions, conceptual frameworks and strategies for action – in other words working models or in Kuhn's (1970) term 'paradigms'. These working models serve as guidelines for the definition of health and disease, the strategies of problem-solving, the structuring of work settings and the organisation of work. The mechanisms of this process are difficult to discern but may include various media as well as formal and informal teaching and communication. At a specific level, medical schools and training institutions equip students or trainees during the process of their professional development with particular sets of attitudes, knowledge and skills which will serve as a basis for their professional identity and commitment, as well as an internal behavioural guide for their professional activities.

In this book it was proposed that medical schools and training institutions should transmit comprehensive working models relevant to primary health care. Unlike biomedical models, which frequently are too restricted in scope, comprehensive models should be appropriate to serve as a basis for the explanation of the etiology and the course of illnesses, and as a guideline for a sufficiently wide range of promotive, preventive, curative and rehabilitative strategies. This implies that comprehensive medical models encompass the relevant concepts and the knowledge of the biomedical sciences and clinical disciplines, of epidemiology and of the social and behavioural sciences.

It was questioned whether this can be accomplished by establishing new departments or by simply adding a few courses in new subjects to the traditional discipline-centred curriculum. Although new departments or other units may be required, it must be regarded as an important principle that a given department structure does not imply a particular structure of the curriculum. Instead, close co-operation of the different scientific disciplines in the health services, in medical and health care research and, especially, in the education and training of health professionals might be crucial. Medical schools or postgraduate training centres could, for example, establish multi-disciplinary and multi-professional model institutions for education and training in primary health care.

Becoming a physician – or professional socialisation in medicine – is to be viewed as an ongoing developmental process consisting of several ordered stages (basic education, vocational training, continuing or recurrent education and training). During each stage the student or doctor in training experiences specific learning or work environments. One of the most decisive factors for his formal and informal learning is the pattern and nature of the student's or trainee's interacting with

science teachers, clinical teachers, patients, peers and other health workers; and his way of coping with their expectations and behaviours, especially his role-playing activities. This conclusion seems to be consistent with more recent research into professional socialisation during the postgraduate stage. This research shows that playing a professional role tends to be much more important for developing a professional identity and commitment as well as for choosing a career than observing role-models, coaching from staff or peers, and peer-group relations (Bucher and Stelling, 1977, pp.226-70).

As he passes through the subsequent stages of his education and training, the doctor interacts with learning and work environments which differ markedly with regard to characteristics such as the nature of tasks or requirements; organisation of work; social relations with other individuals involved; visible role-models; and the status of the student or trainee. This discontinuity in his learning or work experience will be especially pronounced during the transition from the classroom or laboratory to the hospital, and from the hospital to the primary care setting. It can be concluded that the more the learning or work experiences acquired in two subsequent settings differ, the fewer competencies will be carried over from the former to the latter, and hence will be applied in the latter. Extensive research work in the field of diagnostic reasoning (Elstein, Shulman and Sprafka, 1978) appears to be in agreement with this conclusion. The degree of intra-individual consistency in the performance to solve different clinical problems was observed to be surprisingly low, suggesting that in the case of complex tasks such as clinical decision-making there is little transfer from one problem to the other. What seems to be important is a sufficient repertory of experience, resulting in useful prior knowledge of how to solve problems.

To the extent these conclusions are tenable, they can be regarded as general guidelines for educational planning and programme development. Thus, educational and training programmes are likely to contribute more to primary health care, the more they allow students or trainees to play the role of primary care providers; the more similar learning and work environments are, with regard to their content and behavioural expectations; and the greater the continuity of learning experiences and work requirements is.

Besides communicating working models relevant to primary health care, it is the main function of medical schools and training institutions to educate and train a sufficient number of motivated and competent primary care physicians. It was emphasised that these doctors should

have positive *attitudes* towards the functioning of the health care system as a whole, and towards meeting the basic health needs of the population they serve through appropriate primary health services. They should have adequate *knowledge* about the etiology and course of all important illnesses and their biological, psychological and social aspects; about the important strategies and tactics for promoting health and for preventing and controlling disease; as well as about the available health care resources. Furthermore, they should have sufficient *skills* to identify the health problems of individuals and groups; to solve them to the extent possible within the context of primary care settings or to arrange further adequate help; to communicate and co-operate with other persons and institutions; to educate and train patients and other health workers; and to organise and evaluate health care.

It was noted that the specific meanings of such educational aims will always have to be defined by those involved in the educational or training process. Therefore they may vary considerably, depending upon the characteristics and needs of the health services system, the institutions and people involved, and the particular stage of professional development. It was felt that in most systems it should be the function of undergraduate education to prepare the student to choose a specialty (including primary care medicine), while it is the function of postgraduate training to prepare him to practise one. This would imply undergraduate programmes which provide for adequately balanced learning experiences in primary care, specialised care and additional fields such as occupational and environmental health; as well as postgraduate training programmes directed towards the specific professional roles and requirements of primary care physicians. In addition, there will be need for a wide range of efforts in the field of continuing or recurrent education and training.

Implications for Research

There has been some progress in the study of both health services and medical education. Yet considering the value society attributes to health and the cost of health services, the current state of both theoretical analysis as well as of empirical research leaves much to be desired. Without a sufficient knowledge base there can be no rational approach to building stronger systems of primary health care as well as effective programmes for the education and training of primary care providers. It has been suggested in this book and elsewhere that the planning of health services and of medical education and training is primarily a matter of strategy rather than of tactics. Therefore, the

study of these systems should focus on fundamental issues which frequently cannot be analysed with excessive rigour and precision. But in order to improve the quality of decision-making 'it is better to be roughly right than to be precisely or elaborately wrong' (White *et al.*, 1977, p.19).

The following fields of study seem to be fundamental to the development of primary health services and of educational and training programmes in this field:

- *Health needs and health problems* encountered in the population at large, and in primary health services in particular; as well as the relationship between environmental, demographic, social and other important factors and the nature and extent of health problems.

- *Medical working models* which explain the etiology and course of the major categories of illness as well as important patterns of reacting to and coping with illness; and which can serve as a basis for the development and justification of promotive, preventive, curative and rehabilitative strategies.

- *Primary health care institutions*, their organisation and functions as well as related professional roles and requirements; the quality of the services they provide; in addition, their use and the major determinants of use.

- *Professional behaviour of primary care physicians*, in particular specific approaches to problem-solving and particular patterns of interacting with patients or clients; furthermore, the relationship of certain behaviours with institutional, educational and personal factors.

- *Professional socialisation and the development of professional skills*, especially the impact of particular learning and work environments and of educational and training programmes on the development of professional orientations, problem-solving skills and interpersonal skills.

As shown in several parts of this book, these are rather complex fields of study which are likely to benefit from multi-disciplinary work and cross-national efforts, and which call for a wide range of theoretical approaches and for methodological pluralism. The main contribution to these fields would, however, have to come from the social and behavioural sciences. Progress will thus be especially slow in those countries where these sciences have hardly been involved in medical education and research, and where they are not yet sufficiently developed.

Towards a Greater Contribution of Medical Education and Training to Primary Health Care

Countries differ in many ways; and their systems of health care and of medical education and training frequently reflect unique economic, social and cultural traditions. For example, in some countries medical schools have established departments of general practice, family medicine or community medicine in order to teach primary health care (or perhaps more adequately, primary medical care) as well as to train medical generalists and to conduct research into this field. In other countries proposals for such a development meet with considerable resistance. For these very reasons it would be presumptuous to close this book with a list of more or less specific suggestions for 'innovations in medical education'.

Many medical schools have added a new course in general practice to an already crowded curriculum, and others may do so in the future. Similarly, the professional organisations responsible for the postgraduate training of primary care doctors may introduce a certain period of supervised training in designated primary care settings, in addition to several years of clinical work in more or less specialised hospitals. However, such changes should only be an important first step if they are not to become merely window-dressing exercises.

Primary health care reflects a new comprehensive approach to health and health care which in the long run may well have a number of advantages over present approaches. Realistically however, in many countries such an approach could be considered seriously only if it were taken as a long-term goal. Furthermore, to build such primary health services, and to re-direct medical education and training accordingly, may only be feasible if a co-ordinated health and education policy exists, as well as appropriate mechanisms and sufficient resources for implementing it. This will often require that government, medical profession, medical faculties and several other bodies reach consensus about a concept of primary health care for the future, about the organisational structure of primary health services and about a plan of action. There always will be ways and means to introduce certain elements of primary care into an existing programme, in which case policy decisions at the level of postgraduate training institution, faculty or even individual department might be sufficient. However, in the long run it is difficult to see how a new and comprehensive approach to primary health care can become reality without a co-ordinated health and education policy.

Of course, there are no recipes for establishing such a policy; and it

can always be claimed that there is insufficient information or knowledge. Yet usually even the information which is easily available, like some of the research results on morbidity reported in this book, or the knowledge about some of the basic principles of educational planning and development (e.g. Miller and Fülöp, 1974), is rarely being used in formulating a policy and in decision-making. What seems to be needed for shaping a health and education policy is not merely scientific information, but a particular blend of information about the health services system with particular social and political values — a capacity which has been referred to as '*health intelligence*' (White *et al.*, 1977, p.106); and in addition, a particular blend of knowledge about educational, training and socialisation processes with certain social and political values — a capacity which, in analogy, might be referred to as '*educational intelligence*'. It is assumed and hoped that more health intelligence and more educational intelligence will contribute to a wider scope of health services, more adequate models of primary health care, and the education and training of more and more competent primary care physicians.

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EPILOGUE: MEDICAL EDUCATION AND PRIMARY HEALTH CARE: A CRITICAL REVIEW

Michael A. Simpson

One way of defining a bureaucracy might be that it is an organization that has learned so much from the past that it can't learn anything from the present (Holt, 1972). Much the same could be said of medical education and most health care systems. At Berne as at many other conferences on these subjects, a good deal of time was spent writing definitions. One might, indeed, define the Conference on Medical Education as a chronic recurrent condition, like psoriasis or acne vulgaris, where a large number of sincere people get together, write definitions, and prove yet again that teachers rarely learn.

Definitions can cause problems, like the WHO definition of health, describing a state only achieved during orgasm, if then. Perhaps this is why it is rather difficult to achieve in primary health care.

We often behave like theologians debating the nature of sin, but rather successfully and with less social significance. It is for some as if primary care is a concrete *thing*, somewhere 'out there' like the Matterhorn, waiting for us to discover, photograph and measure it, rather than an amorphous creation of our own. There is a need to agree on what we are talking about, but definitions arrived at by large groups are seldom of value. The price paid for consensus is a progressive dilution of relevance and significance: they become statements of the sort Noam Chomsky once described as having the benefit of being true, without the benefit of being interesting.

There is a confusing excess of terms. We may read of the general practitioner (GP), the family doctor, the doctor of first contact (as if medicine were infectious), the front-line doctor (as if it were a war), the primary care physician, the generalist, and many others. Janeway (1974) has made a useful attempt to clarify the jargon (jargon should be regarded as being in the same chemical series as argon and neon: an inert gas). He sees primary care as first-contact medicine – that which could be delivered by any physician who is prepared to practise in a community and to see whoever comes to him for medical advice. In Britain, then, primary care is actually provided by the GP and by hospital emergency rooms; in the USA, it is also provided by some specialists. Increasingly, such primary health care may be provided by

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special professionals such as the nurse practitioner, physician's assistant etc. He defines family practice as primary care provided by physicians specially trained for the job (presumably equivalent to general practice). It is a specialisation in its own right, with an emphasis on ambulatory (not hospital-bed-oriented) care, on early disease recognition and prevention, and on functioning at least in part in triage and as a patient advocate, to help guide her or him through the complex health care system. This specialty is defined by the primary level of organisation of care, unlike others which may be defined by age (pediatrics, geriatrics), sex (gynecology), body system (cardiology), technique (surgery) or pathological process (infectious disease, immunology).

Family medicine is a discipline which 'puts the family into the centre of medical care delivery' (Janeway, 1974) with a central concern for the family as an ecological and social unit and a dynamic interpersonal system. This is an attitude or stance (it is often no more developed than that, and to call it a discipline is polite but optimistic) which can affect any area of medical care, though there is little evidence as yet, to support this view. If we are concerned more with seeking truth than with intellectual or emotional titillation, then the more attractive a postulate, the more fiercely should we challenge and test it. This latter-day fashion for family chic may be a distractor, a placebo, a surface decoration of an unchanged system that needs more radical change.

At the Berne meeting, and occasionally in this book, there is confusion between these different terms and varieties of health care. For example, while general practice is usually primary care, primary care absolutely is not general practice.

In our currently fashionable (and generally appropriate) criticism of hospital specialty practice, it is too often too readily assumed that current primary care is free of the same faults and will lead us to a better world if only we can have more of it. Noack and Müller (pp.39-80) demonstrate the complexity that underlies the question of what constitutes health needs and wants. Certainly, the teaching hospital is an inappropriate setting in which to train primary care practitioners, for it sees only a fragment of morbidity; important, but not a representative sample of the problems of the population at large.

But even the frequenters of the GP surgery or primary care clinic fail to represent the natural occurrence of illness, rather than merely a different sample. Marinker (pp.103-11) describes the hospital setting as a clinical zoo, but he leans too heavily on a romantic variety of the 'noble savage' myth (more Rousseau than Foucault) in assuming that

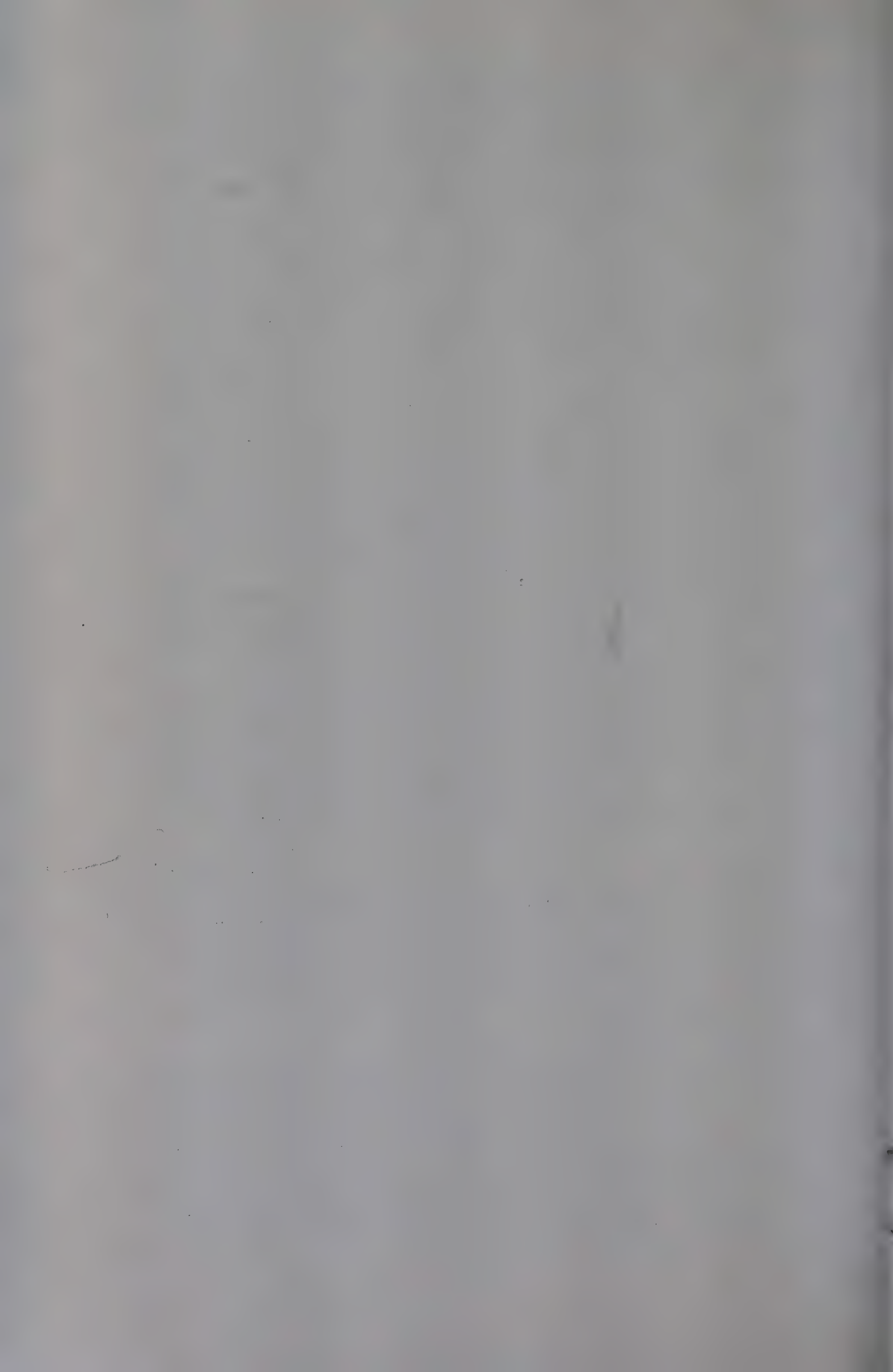
the GP sees life in the raw, in a 'nature reserve in which the student might observe the wild life of unhealth in its natural habitat', rather than simply in an alternative unnatural habitat. One might, using the dramaturgical metaphor of sociology and social psychology (see Brisset and Edgley, 1975), see the primary care clinic as an audition room, where the new arrivals offer a sickness role. They may be rejected (to return later, to try another role in another production); they may go away to practise their role and return for a further audition; they may receive some coaching in their role from the doctor; or they may be accepted and may even be sent on to the hospital to continue to develop the role (they may ultimately actually appear in the theatre).

Strangely, few people seemed to doubt that we are the right people both to question the existing system, and to answer our own questions. Few were bothered by the conflict of interests inevitable in having the major health professionals decide what they should do, to whom, when and for how much. To put it simply: if you want to make an omelette, don't ask the exclusive advice of a hen. She is also very interested in eggs, but her motivation is very different from yours.

Otherwise, we merely indulge in re-polishing the monopoly. Brown (1974), for example, has estimated that in Canada medical incomes are roughly 50 per cent higher than they would be if medical services were supplied on a competitive basis. The high medical incomes are maintained by restricting both the number of physicians (limiting the growth of medical schools and restricting the inflow of foreign medical graduates, as both America and Britain have recently decided to do) and by restricting the activities of other health professionals (limiting what they do, and insisting that it must be done under medical supervision).

Unless one accepts some variety of cosmic conspiracy theory, one must seek to understand how our present system arose rather than simply growing concerned, as did Knecht (in Hermann Hesse's *Glass Bead Game*), about the dangerous lack of relevance to nature and society of our glass bead game. (In our universities, Castalia opened branch offices long ago.)

In acts of the worst sort of cultural imperialism (though very well-meant – so many of mankind's cruellest acts have been well-meant) we exported the great medical schools, on the British, German and later American models, to other countries. They were institutions not really fit to produce the manpower necessary for the health needs of their parent countries – they were often grotesquely unrelated to the needs of the developing nations, where they perverted the nature of health



care for decades. Their graduates naturally migrate towards the 'centre of excellence' they have learned to value, or demand inappropriate resources at home. Now Britain and America, inappropriately alarmed by a supposed domestic overproduction of doctors (Stevens, Goodman and Mich, 1978), are disowning their bastard offspring: an action even less moral than begetting them in the first place.

Flexner may have produced an improvement over the preceding chaos, but caused the different variety of chaos which succeeded him; a man of great energy and a seriously limited understanding of the nature of medicine. According to many aspects of the modern philosophy of science, one can argue that medicine is not a science, never has been a science, and should not be a science. But the Flexnerian model regarded medical practice as an applied science, a detailed training in science as the essential prerequisite for becoming a good doctor, and the medical school as necessarily dominated by powerful bioscience departments.

But the science professor must not be allowed any influence over the selection of medical students nor allowed to decide the content of the curriculum. (Ask not what the curriculum can do for you: ask what you can do for the curriculum.) He must not, though, have his income, staffing or satisfaction dependent on the medical students — or the number of hours of, say, biochemistry, essential to the basic training of the primary care physician, will be equal to the number that brings his department what it needs.

The student needs to gain a friendly familiarity with the shape of the sciences, so he can return to them if and when necessary. We must not overemphasise the need for him to be enabled to do research. Most doctors will not do research, and many should not do research; they should learn appropriate hypothesis-testing and the elements of scientific methodology so that they can critically assess new proposals and treatments suggested to them, and the data offered in support of such claims. This cannot be achieved by more 'basic science' teaching of the traditional sort, which has conspicuously failed to produce any such results.

There is generally no one in the medical school (the dean's was and is an administrative and political position) who has the responsibility, power or ability to see what the system as a whole is doing or not doing. Whatever plans the school has (and until quite recently, there were no coherent plans) there is little or no mechanism by which it can discover whether it is actually carrying out its own plans (often it is not doing so), let alone accurately assessing the effects of its actions. Many of

those well capable of improving the situation are too busy doing real health care to become locked in the council-rooms fighting for a better curriculum. (Oscar Wilde said that the trouble with Socialism is that it would take up too many evenings.) There may be innumerable committees, mainly battlegrounds for interdepartmental struggles and trials of strength, but still little or no capacity for the institution to think, plan or function as a whole. We need a teaching institution that is a learning institution, which can perceive and respond cohesively.

The medical schools have had the wrong sort of autonomy. They saw themselves as self-contained independent bodies, answerable to no one, existing of and for themselves. Failures of primary care were failures of other people, elsewhere; sad, perhaps, but nothing to do with the medical school itself. 'If my students don't enter primary care, well, someone else's students can do so.' But no school is an island. They fostered the illusion that these 'centres of excellence' dealt with the only really important type of medical care, though their standards were autistic. Their 'excellence' didn't look very impressive for the urban ghetto or the rural village.

The creation of departments of social, preventive or community medicine, departments of general practice or family medicine, has had relatively little impact; this has often been tokenism rather than substantive change. There is a dilemma. If such departments are not respected or treated seriously throughout the curriculum, they are likely to have little impact. Yet by competing in the same terms as the other departments, they have often failed to gain respect, acceptance or power, at the cost of losing their soul, becoming abstract, intellectual, scientific, and no more human or conscious than any other part of the medical centre machine.

This book reviews much of what is known about current health needs and their assessment. It is not sufficient simply to try to address the curriculum to such primary health needs. We need ways to keep the medical school interested in, wanting to, and able to, continue to attend and minister to the state of the community and its needs. We need, as I have described in the context of continuing education in the health sciences (Simpson, 1978), a continuing, spiral process of matching needs to services and training. Universally appropriate solutions and programmes are not possible; they need to be evolved locally by the people who will have to carry them out. The contributors to this book suggest better ways of seeking those solutions.

Bloom and Shuval review studies of the professional socialisation process by which a 'student' becomes a 'doctor', and Bergman stresses



the importance of interpersonal skills. Bloom asks whether the new teaching processes demonstrably affect the student's attitudes and skills. Recent work, including my own research, has shown that carefully planned and executed programmes can influence students' attitudes in the direction we desire, producing change not only in the attitudes they express, but in what they do in their daily work. Similarly, one can improve interpersonal and communication skills significantly, both as judged by professional raters, and as judged by the patients. But you can't change the momentum of super-specialisation by some lectures on epidemiology. Only teachers with an unashamed and radiant passion for holistic health care are likely to have a useful impact on the students.

Finally, we must avoid falling victim to the great fallacies that obstruct our progress by promising magic answers. There is the communications fallacy, believing that if somehow we can just communicate better, we will be able to solve all problems, whatever the social, political and economic determinants of the communication. We have Pickering's Fallacy, which sees the multiple-choice question as leading us into a new Dark Age, only to be avoided by returning to obsolete methods. We have those who believe that writing behavioural objectives, or problem-oriented medical records, will solve our problems. (Only very clever people can be so naive.) But better communication, objectives or records, are an opportunity, not an answer. Like a language, they offer us a way of saying things, but they do not tell us what to say, and they do not enable us to say all that needs to be said.

Anyone who is certain he knows what primary care is, and what to do about it, won't have read this book. He will be sulking because he wasn't asked to write it. He may accuse us of being too subjective in our comments — though 'objective' is simply what people call subjectivity they happen to agree with. But in an area as problematic and significant as this, he who is sure he knows the answers, hasn't understood the question.

At the end of a lecture, J.L. Austin, the philosopher, was asked 'What you have said may be true, but is it important?' It is said that Austin replied: 'I am not sure that importance is important. Truth is.'

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INDEX

- Abelin, Theodor 238-48, 338
- Agents: socialising of student groups 164, 166
- Aims: of family medicine 260; of students and their careers 290; of teaching medical sociology 295-96
- Aims and objectives of educational and training programmes in Primary Medical Care 215-18
- Ambulatory: care 47, 57, 59, 62; patient 52
- Analysis: system and curriculum development 195
- Approach: biomedical 25, 40; holistic 55, 71, 74; problem-based 190-92; traditional 189-90, 194
- Approaches: to curriculum development 194-96; to educational planning 214-15; interdisciplinary 259; need based 214; problem based 214
- Armstrong, David 81-9, 338
- Assessment: and evaluation 227-8; forms and criteria of 202-4; forms of appraisal 202; methods 204-6; of students' competencies 220
- Association for Medical Education in Europe 332
- Attitudes: learning modalities of 150-1; of primary care physicians 215; of students 148-50; towards Primary Health Care 176-7
- Auxiliary workers, training and use 32
- Barr, Daniel M. 118-29
- 'Basic Doctor' 176-183
- Basic sciences: importance of 308; and the primary care physician 306
- Behaviour: aspects of, in health 63; aspects of, in illness 63-70
- Behavioural scientist: and evaluation of the effectiveness of medical education 145-6, 147
- Behavioural and social science: arguments against 300-1; contributions of 301-4; integrated course in 298-9; and the primary care doctor 300; the role of 306
- Bergmann, Rebecca 231-7, 338
- Biomedical: approach 25, 40; intervention 40; model 40
- Bloom, Samuel W. 144-56, 338
- Care: ambulatory 47, 57, 59, 62; of the chronically sick at home 269-70; comprehensive 152; of the dying 270-1; levels of 12; self 63; specialised 122-3; problem solving in 124
- Careers: selection, factors affecting 281-2, 283
- Causal explanation: changes in 41; modern 41, 42
- Change in medical education: obstacles to 177-9; rewarding 220
- Characteristics: of students 147; of students' role 163
- Client: practitioner relationship with 231, 233; role of 94
- Clinic: advent of modern 106-7; critique of the structure of 106; as defined by Foucault 106
- Clinical: disciplines in undergraduate medical education, the role of 282-4, 285, 309; 'gaze' 84, limits of 88-9; and Primary Health Care needs 89; practice in Primary and Specialised Care compared 120-5; records 204
- Code: collection (Bernstein) 86; integrated 87
- Communications 326; with patients 68, 264
- Community medicine, departments of 325
- Comparison: of clinical practice in primary and specialised care 120-5; of knowledge and techniques in primary and specialised care 120; of primary

